Byron A. Eliashof, M.D.
615 Piikoi Street
Suite 1509
Honolulu, HI 96814-3142

COPY

NOTICE OF INFORMED CONSENT

This is to verify that I have been scheduled to undergo an independent medical evaluation related to my claim of disability at the office of Byron A. Eliashof, M.D. on 7-12-05 at 8:15 (A.M.)/P.M.

I understand that this evaluation is to include my giving information about myself and my personal circumstances as well as my health.

I understand that the results of the evaluation are not confidential and will be sent to the party who has requested this examination. I understand that my authorization is not required for the release of information obtained during the course of the examination.

I understand that any information developed as a function of my participation in the evaluations will be used only as it relates directly to the evaluation or proceedings resulting from that evaluation. This does not establish a doctor/patient relationship and no treatment will be undertaken.

I understand that the results of the evaluation will not be given to me by the examining doctor, but that all of the findings will be neutral (that the evaluator is completely independent and not involved in my disability claim or the results thereof).

Ofelia Cabagan
(Signature)

7-12-05
(Date)

Exhibit 3